Mail to:
Insurance Carrier Name: _____ State File #: _____
Insurance Carrier Address: _____ Ins. Co. File #: _____
Insurance Carrier City/State/Zip: _____ Date of Injury _____
Insurance Carrier Adjuster: _____

Mileage Reimbursement Request

Employee Name _____ Employer Name _____

Employee Address _____ Employer Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Daytime Phone _____ Employer's Phone _____

Worksite Address: _____

You may be eligible for mileage for medical appointments, insurer scheduled visits or vocational rehabilitation. Please note only mileage beyond the distance normally traveled to the workplace is allowed (WC Rule 12.2100 and Rule 58.7100). **In other words, if you regularly commute 25 miles ROUND TRIP to work each day, only mileage above that amount will be reimbursed.**

Round Trip Mileage to Work:

Date/Time of Visit	Who/Where Visited – Official Name	Traveled From (City/Town)	Traveled To (City/Town)	Round Trip Mileage	Reimbursable Mileage

I hereby affirm that all mileage listed above was for travel required regarding a valid workers' compensation claim:

_____ _____

Signature Date

Current mileage reimbursement rates are available at: http://www.labor.vermont.gov/Portals/0/WC/mileagemealrates.pdf